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TO: The Honorable Brian Boquist, Chair
Senate Committee on Veterans and Emergency Preparedness

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SUBJECT: SB 1054 – Certificate of Need Exemption

Chair Boquist and members of the committee; I am Dr. Dana Selover, Manager of the Health Care Regulation and Quality Improvement Section for the Center for Health Protection, Public Health Division, Oregon Health Authority (OHA). I am here today to provide information about the Certificate of Need process and SB 1054.

Background:

Certificate of Need (CN) programs are regulatory programs designed to discourage unnecessary investment in health care facilities, technology and services. As the name implies, the purpose of these programs is to evaluate the plans for a service or facility being considered in order to certify that there is a real need for it. Historically, the focus of such programs has been to promote access, ensure quality, and help control costs by limiting market entry to those facilities and services that are found to be needed, appropriately sponsored, and designed to promote quality and equitable access to care. Each state CN program implicitly incorporates these principles by predicating certification of regulated services on the basis of community or public need.

Unnecessary investment in unneeded facilities and services may result in the building of facilities that are not financially viable and may also put financial stress on existing providers resulting in higher costs and disruption to the health care system.

Oregon has had a CN program since 1971. Nationally, 34 states plus Puerto Rico, the US Virgin Islands and the District of Columbia have CN programs. Three additional states have variations of the program. The scope of these programs varies widely with Oregon's

program ranking as one of the most narrowly focused programs nationally. Historically, the CN program in Oregon was applied to an extensive variety of health care facilities, services and equipment but the scope of review continued to be narrowed over time until 1995 when the current parameters were set.

Billions of state and federal dollars are spent on health care. CN programs are one of the few ways that government and the public have a say in developing health care services. CN requirements do not block change, they mainly provide for an evaluation and, as is the case in Oregon, include public or stakeholder input.

What does Oregon's Program Cover?
The scope of review in Oregon is limited to: (1) new hospitals and (2) new nursing facility services or facilities. While nursing facility projects are fairly well covered, CN oversight of hospital-related projects is very limited compared to other states with CN.

What are the Goals of the Program and How Does it Achieve Those Goals?
CN has a 46-year history in Oregon. The program arose out of the Legislature's desire to achieve reasonable access to quality health care at a reasonable cost. The program uses two primary methods to control costs. First, it attempts to limit the number of beds, in order to maintain an efficiently high occupancy rate. Second, it tries to ensure that services are provided in a cost effective and fiscally responsible manner. Excess capacity stemming from the overbuilding of health care facilities results in health care price inflation. This can occur when facilities cannot fill beds and fixed costs must be met through higher charges for the beds that are used.

States that have attempted to discontinue their CN activities have generally found that once CN laws are repealed there is significant growth in the number of long term care beds. Since this adversely affects occupancy rates (i.e., facilities are not filled to optimal capacity and total public expenditures for long term care increases), a new restriction is then put in place, often through the use of a moratorium. CN has proven itself to be an effective mechanism for regulating the growth of nursing facilities and limiting the rise in Medicaid expenditures.

In relation to quality of care, a study of CN regulations on treatment outcomes found that open heart surgery mortality rates are more than 20% lower in states with CN regulations than in states without regional planning and regulation. (*JAMA*, Volume 288 No. 15, October 16, 2002, 1859-1866.) Further information on state CN programs is available from the National Conference of State Legislatures:
http://www.ncsl.org/programs/health/cert-need.htm.

How is the Program Supported?
The CN program is funded by application fees. One part-time program coordinator is its only staff. The CN program contracts with other professionals in conducting its reviews.

SB 1054-1

This bill with -1 amendment will exempt any hospital from the requirement to obtain a CN to construct a new facility or to expand capacity to provide psychiatric services or inpatient chemical dependency services if the hospital receives reimbursement for medical care by the U.S. Department of Veterans Affair (VA) through TRICARE or by Section 101 of the Veterans Access, Choice and Accountability Act of 2014. This Act created by SB 1054 would sunset two years after its effective date.

Regarding the reference to expanding capacity to provide psychiatric services or inpatient chemical dependency services, hospitals already have the ability to expand capacity to provide these services without CN review as long as it is allowed under their license category and if there are no conditions of approval that have been placed upon a CN issued to them.

This bill has the potential to result in excess capacity and duplication of inpatient psychiatric and chemical dependency services without review of new hospitals by the CN program. Within the 2 year duration of this act, it could result in an increased number of specialty hospitals that are faster, cheaper and easier to build than facilities providing comprehensive medical services.

In some instances, it may promote utilization of hospital services when alternatives to hospitalization are more cost effective and beneficial.

Thank you for the opportunity to testify. I'd be happy to answer any questions.